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WEEKLY REPORT

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Public Health Dispatch

Certification of Poliomyelitis Eradication — Western Pacific Region, October 2000

On October 29, 2000, the Regional Commission for the Certification of Poliomyelitis Eradication certified that the Western Pacific Region (WPR) of the World Health Organization (WHO) is free of indigenous wild poliovirus transmission. The last known case of indigenous poliovirus transmission occurred in Cambodia in March 1997 in a 15-month-old girl. WPR is the second of the six WHO regions to be certified as poliomyelitis-free; the first was the Region of the Americas in 1994 (*1*). WPR comprises 37 countries and territories* (Figure 1) with an estimated 1.6 billion persons (27% of the world's population) (*2*).

The commission completed a 5-year review of programmatic data compiled by national certification committees to ensure that the absence of reported wild poliovirus isolation reflected interruption of indigenous transmission. The prerequisite for regional certification is the absence of indigenous wild poliovirus isolation for at least 3 years (*3*). Other criteria used to certify that countries and regions are polio-free include 1) high vaccination coverage rates in all countries and within all areas of a country; 2) sensitive surveillance for detecting all cases of acute flaccid paralysis (AFP) meeting standard performance indicators (e.g., the processing of all stool samples from AFP case-patients in WHO-accredited laboratories); 3) a plan of action to respond to imported cases of polio and poliovirus; and 4) political commitment by national governments to maintain polio eradication activities at current levels of intensity until at least 2005.

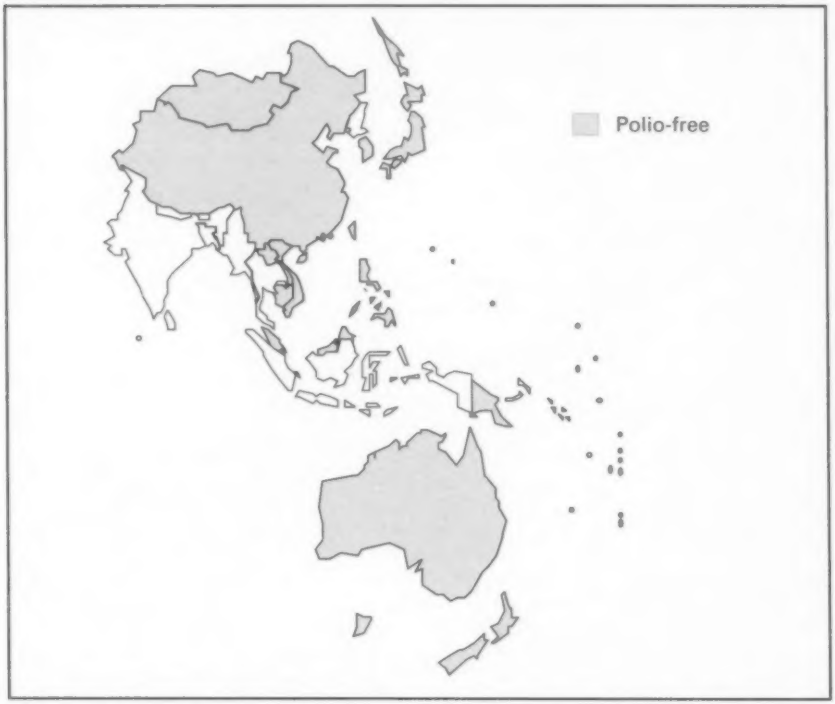
WPR is the first region to include the biocontainment of wild polioviruses in laboratories as part of the certification process. In its initial phase, this process entails conducting inventories of all stocks of wild poliovirus infectious materials and potentially infectious materials. Completion of this phase in WPR is expected in December 2001.

In 1988, the Global Poliomyelitis Eradication Initiative was established by the World Health Assembly and was coordinated by WHO, the United Nations Children's Fund (UNICEF), Rotary International, and CDC; it is the largest public health effort for disease eradication. National governments, private foundations, nongovernmental organizations,

*American Samoa, Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, French Polynesia, Guam, Hong Kong/China, Japan, Kiribati, Republic of Korea, Lao People's Democratic Republic, Macao/China, Malaysia, Marshall Islands, Micronesia, Federated States of Mongolia, Nauru, New Caledonia, New Zealand, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Philippines, Pitcairn Islands, Samoa, Singapore, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam, Wallis and Futuna Islands.

Poliomyelitis Eradication — Continued

FIGURE 1. Countries and territories* certified free of wild poliovirus — Western Pacific Region, 2000



* American Samoa, Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, French Polynesia, Guam, Hong Kong/China, Japan, Kiribati, Republic of Korea, Lao People's Democratic Republic, Macao/China, Malaysia, Marshall Islands, Micronesia, Federated States of Mongolia, Nauru, New Caledonia, New Zealand, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Philippines, Pitcairn Islands, Samoa, Singapore, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam, Wallis and Futuna Islands.

corporations, and volunteers have collaborated to achieve eradication. In the European Region, no new indigenous polio cases have been detected since November 1998. Twenty countries in the three other WHO regions (Africa, Eastern Mediterranean, and South-East Asia) anticipate continued poliovirus transmission; global circulation of poliovirus may be interrupted by 2002 (*4*).

The occurrence of an imported case of polio in China in October 1999 (*5*) and the documented transmission of wild poliovirus in areas bordering WPR during 2000 (*4*) underscore that the continued circulation of poliovirus in the three WHO regions pose a risk for reintroduction to all polio-free countries. Polio-free countries should maintain high levels of polio vaccination coverage and sensitive surveillance for the prompt detection of any circulating poliovirus. To minimize the risk for poliovirus importation, supplementary vaccination campaigns will be required in high-risk areas, especially those bordering

Poliomyelitis Eradication — Continued

countries where polio is endemic. During 2000, an outbreak of vaccine-associated polio was documented among populations with low poliovirus vaccine coverage in the Dominican Republic and Haiti (*6*). Global certification of polio eradication will be required before consideration of discontinuing polio vaccination.

Reported by: Western Pacific Regional Office, World Health Organization, Manila, Philippines. Vaccines and Other Biologicals Dept, World Health Organization, Geneva, Switzerland. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

References

1. CDC. Certification of poliomyelitis eradication—the Americas, 1994. MMWR 1994;43:720–2.
2. World Health Organization. The last polio cases in the Western Pacific Region. WHO in action 2000;1(October):3. Available at http://www.wpro.who.int/newsletter.asp. Accessed January 2001.
3. Expended Programme on Immunization. Report of the first meeting of the Global Commission for the Certification of the Eradication of Poliomyelitis. Geneva, Switzerland: World Health Organization, 1995 (Document no. WHO/EPI/GEN/95.6).
4. World Health Organization. Global polio eradication initiative. Strategic plan 2001–2005 (WHO/Polio/00.05). Geneva, Switzerland: World Health Organization, 2000.
5. CDC. Importation of wild poliovirus into Qinghai Province—China, 1999. MMWR 2000;49:113–4.
6. CDC. Outbreak of poliomyelitis—Dominican Republic and Haiti, 2000. MMWR 2000; 49:1094,103.

Progress in Development of Immunization Registries — United States, 2000

Immunization registries are confidential, population-based, computerized information systems that attempt to collect vaccination data about all children within a geographic area (*1*). Registries are an important tool to increase and sustain high vaccination coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices for each child, and providing official vaccination forms and vaccination coverage assessments. One of the national health objectives for 2010 is to increase to 95% the proportion of children aged <6 years who participate in fully operational population-based immunization registries (objective 14.26) (*2*). To assess the status of immunization registry development, CDC analyzed self-reported data from 62 immunization grantees on the basis of data from the 2000 Immunization Registry Annual Report (IRAR). This report summarizes the results of this analysis, which indicate that approximately half of the grantees are operating population-based immunization registries that target their entire catchment areas; however, approximately 75% of children aged <6 years still need to be included in an immunization registry to reach the national health objective.

The 2000 IRAR was a self-administered questionnaire distributed to immunization program managers or immunization registry managers that requested information on the enrollment status of a registry's target population and the implementation of 13 functional standards (Table 1) considered essential for immunization registry operation (*3*). Key elements for each of the 13 standards were defined by the Immunization Registry Technical Working Group (IRTWG) and are used to measure registry development. The 2000 IRAR also collected data on provider participation and other electronic information systems that shared data with the registry.

Immunization Registries — Continued

TABLE 1. Number and percentage of population-based immunization registries that implemented key elements of the 13 functional standards — United States, June 2000

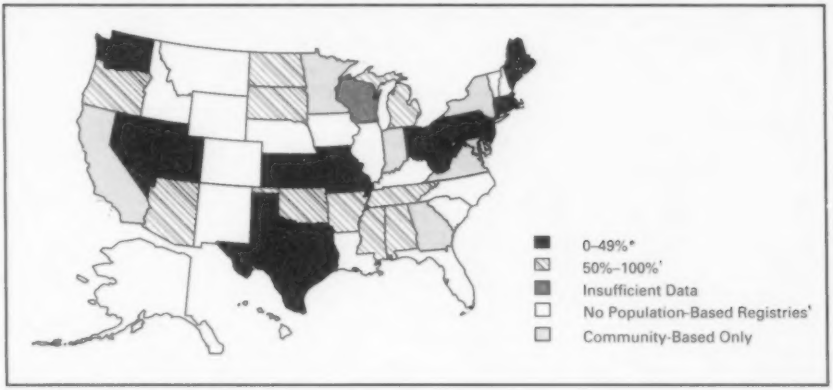
Functional standard	Registries meeting all key elements No.	(%)	Registries meeting ≥1 key elments No.	(%)
Electronically store data on all National Vaccine Advisory Committee-approved core data elements	21	(65.6)	32	(100.0)
Establish a registry record within 6 weeks of birth for each newborn child born in the catchment area	29	(90.6)	29	(90.6)
Enable access to vaccination information from the registry at the time of encounter	29	(90.6)	30	(93.8)
Receive and process vaccination information within 1 month of vaccine administration	28	(87.5)	32	(100.0)
Protect the confidentiality of medical information	6	(18.8)	28	(87.5)
Ensure the security of medical information	28	(87.5)	32	(100.0)
Recover lost data (disaster recovery)	26	(81.3)	32	(100.0)
Exchange vaccination records using Health Level 7 standards	4	(12.5)	8	(25.0)
Automatically determine the immunization(s) needed when a person presents for a scheduled vaccination	28	(87.5)	28	(87.5)
Automatically identify persons due/late for vaccinations to enable the production of reminder/recall notifications	25	(78.1)	30	(93.8)
Automatically produce vaccination coverage reports by providers, age groups, and geographic areas	24	(75.0)	29	(90.6)
Produce authorized immunization records	27	(84.4)	27	(84.4)
Consolidate all vaccination records from multiple providers, using deduplication and edit checking procedures to optimize accuracy and completeness	28	(87.5)	32	(100.0)

In April 2000, CDC's 64 immunization grantees (50 states; the District of Columbia; Chicago, Illinois; Houston, Texas; New York, New York; Philadelphia, Pennsylvania; San Antonio, Texas; American Samoa; Guam; Marshall Islands; Micronesia; Northern Mariana Islands; Puerto Rico; Republic of Palau; and the U.S. Virgin Islands) were asked to complete the 2000 IRAR; 62 (97%) responded. Thirty-two (52%) of the 62 grantees (26 states, four cities, and two territories/commonwealths) reported operating population-based immunization registries that targeted their entire catchment areas. Of the remaining 30 (48%) grantees, seven operated population-based registries in regions or counties as demonstrations or pilot projects, and 23 were planning to develop population-based registries.

Data from 31 of the 32 grantees operating population-based registries indicated that approximately 46% of the estimated 10.4 million target children aged <6 years in these catchment areas had received at least two doses of vaccine. The two doses typically included one vaccine dose in addition to the dose of hepatitis B vaccine given at birth and recorded in a population-based registry's database (Figure 1). The 32 grantees also

Immunization Registries — Continued

FIGURE 1. Percentage of children aged <6 years with immunization history included in population-based immunization registries — United States, June 2000



*Fourteen states and Puerto Rico.
†Eleven states and the District of Columbia; New York, New York; Philadelphia, Pennsylvania; San Antonio, Texas; and the Republic of Palau.
§Twenty-four states and Chicago, Illinois; Houston, Texas; American Samoa; Guam; Northern Mariana Islands; and the U.S. Virgin Islands.

reported that an average of 74% of public vaccination provider sites and 44% of private provider sites participated in a population-based registry during the 6 months preceding completion of the 2000 IRAR. All 32 grantees implemented at least one key element on nine of the 13 functional standards (Table 1). Six (19%) of the 32 grantees reported implementing at least one key element in each standard. However, none had implemented fully all key elements of the 13 functional standards.

Thirty-one of the 32 grantees reported electronic linkages (sending and/or receiving electronic data) between immunization registries and at least one other information system. Of these, 28 were linked electronically to their vital records department (Figure 2).

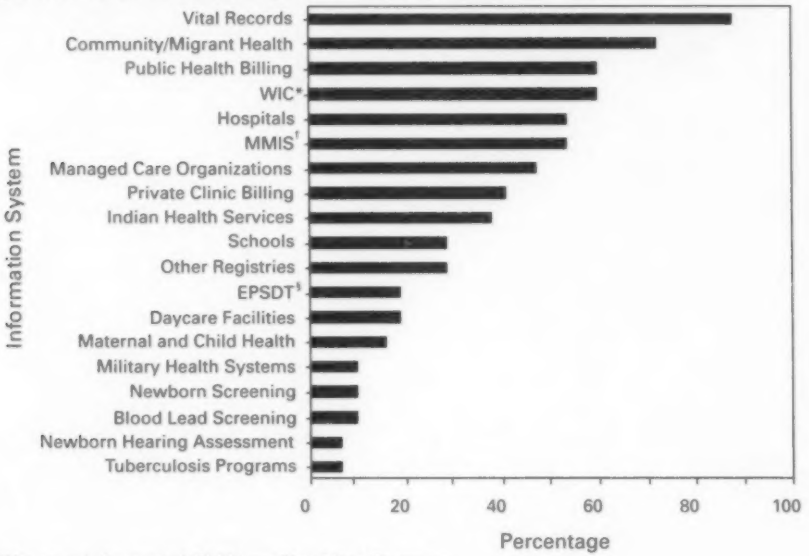
Reported by: Systems Development Br, Data Management Div, National Immunization Program, CDC.

Editorial Note: The findings in this report indicate that an estimated 21% of children aged <6 years have their immunization histories included in a population-based immunization registry. Four major issues may limit registry participation and development: protecting the privacy of persons and the confidentiality of registry information, ensuring provider participation, overcoming technical and operational challenges, and determining resources needed to develop and maintain immunization registries (*1*). To protect the privacy of patients, providers, and other participants of these systems, CDC developed privacy specifications and implementation guidelines in 2000 (*4*).

Ensuring provider participation in registries is critical to attaining complete and accurate electronic immunization records. By age 2 years, approximately 23% of children have seen more than one immunization provider (*5*). When most or all immunization providers in a registry's catchment area participate in a registry, scattered records can be consolidated and appropriate vaccination decisions can be made based on accurate and complete information. Data from San Bernardino, California, indicate that in 1999,

Immunization Registries — Continued

FIGURE 2. Percentage of population-based immunization registries with electronic linkages with other information systems — United States, June 2000



*Women, Infant, and Children Nutrition Program.
†Medicaid Management Information System.
§Early Periodic Screening, Diagnosis, and Treatment Program.

approximately 2000 children received at least one unneeded dose of vaccine because of incomplete immunization records (San Bernardino Department of Public Health, unpublished data, 2000). A national survey in 1997 indicated that an estimated $26.5 million could have been saved by avoiding unneeded doses (*6*).

Because registry development initially was targeted at the public sector, the proportion of public vaccination provider sites participating in registries is considerably higher than that of private provider sites. Increasing private provider recruitment efforts will be critical as immunization services continue to shift to the private sector (*7*).

CDC and IRTWG are finalizing criteria to measure the progress being made toward achieving the national health objective for 2010 (*2*). Progress toward reaching these criteria will be evaluated through annual National Immunization Program on-site visits, and recommendations and feedback will be provided.

Although developing and operating immunization registries can be expensive (CDC, unpublished data, 2000), a fully operational population-based registry offsets many other costs by avoiding duplicate immunizations, limiting the cost of missed appointments through the use of reminder/recall notices, reducing vaccine waste, and reducing the staff time required to find and/or produce immunization records or certificates. Registries also can play an important role in assisting vaccine safety efforts and can be used for vaccine ordering, inventory control, and vaccine use monitoring.

Immunization Registries — Continued

The findings in this report are subject to at least two limitations. First, because IRAR 2000 relied on self-reported information, some bias is expected. On-site verifications of these data are being conducted. Second, because only immunization grantees were surveyed, these data underestimate the degree of registry activity in the United States. Survey respondents reported an additional 22 population-based registries operating in local communities.

Additional information on immunization registries is available from CDC's immunization registry World-Wide Web site, http://www.cdc.gov/nip/registry; by telephone, (800) 799-7062; or e-mail, siisclear@cdc.gov.

References

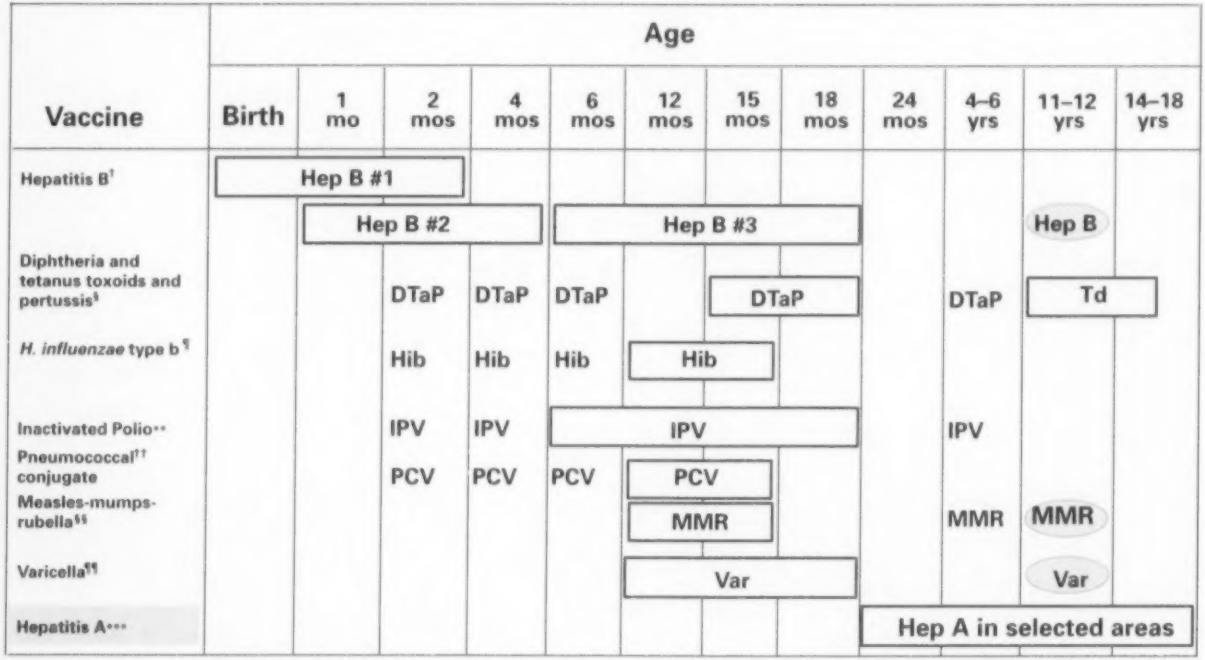
1. The National Vaccine Advisory Committee. Development of community and state-based immunization registries, January 12, 1999. Available at http://www.cdc.gov/nip/registry/i_recs.htm. Accessed October 2000.
2. US Department of Health and Human Services. Healthy people 2010 (conference ed, vol 1). Washington, DC: US Department of Health and Human Services, October 2000. Available at http://www.health.gov/healthypeople. Accessed August 2000.
3. CDC. CDC/NIP 2000 immunization registry annual report. Available at http://www.cdc.gov/nip/registry. Accessed November 2000.
4. All Kids Count of the Task Force for Child Survival and Development. The National Immunization Program of the Centers for Disease Control and Prevention. Community Immunization Registries Manual, Chapter 2, February 2000. Available at http://www.cdc.gov/nip/registry/download/cirman2.wpd. Accessed October 2000.
5. Rodewald L, Peak R, Ezzati-Rice T, Zell E, Thompson K. Who are the immunization providers for U.S. children: findings from the 1994 National Health Interview Survey (NHIS) Provider Record Check (PRC). Ambulatory Child Health 1997;3:168.
6. Feikema SM, Klevens RM, Washington ML, Barker L. Extraimmunization among US children. JAMA 2000;283:1311.
7. Szilagyi PG, Humiston SG, Shone LP, et al. Impact of vaccine financing on vaccinations delivered by public health clinics. Am J Public Health 2000;90:739–45.

Recommended Childhood Immunization Schedule — United States, 2001

Each year, CDC's Advisory Committee on Immunization Practices (ACIP) reviews the recommended childhood immunization schedule to ensure that it remains current with changes in manufacturers' vaccine formulations, revisions in recommendations for the use of licensed vaccines, and recommendations for newly licensed vaccines. This report presents the recommended childhood immunization schedule for 2001 (Figure 1) and documents the changes that have occurred since the January 2000 publication (*4*).

For 2001, ACIP, the American Academy of Family Physicians, and the American Academy of Pediatrics have added pneumococcal conjugate vaccine to the schedule (*2*) and have extended the recommendation for the use of hepatitis A vaccine to include persons through age 18 years in selected geographic areas and in certain high-risk groups (*3*). Detailed recommendations for using vaccines are available from the manufacturers' package inserts, ACIP statements on specific vaccines, and the 2000 Red Book (*5*). ACIP statements for each recommended childhood vaccine can be viewed, downloaded, and printed from CDC's National Immunization Program World-Wide Web site, http://www.cdc.gov/nip/publications/ACIP-list.htm.

FIGURE 1. Recommended childhood immunization schedule* — United States, January–December 2001



Range of recommended ages for vaccination.

Vaccines to be given if previously recommended doses were missed or were given earlier than the recommended minimum age.

Recommended in selected states and/or regions.

* This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of November 1, 2000, for children through age 18 years. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturer's package inserts for detailed recommendations.

† **Infants born to hepatitis B surface antigen (HBsAg)-negative mothers** should receive the first dose of hepatitis B vaccine (Hep B) by age 2 months. The second dose should be administered at least 1 month after the first dose. The third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose, but not before age 6 months. **Infants born to HBsAg-positive mothers** should receive Hep B and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1–2 months and the third dose at age 6 months. **Infants born to mothers whose HBsAg status is unknown** should receive Hep B within 12 hours of birth. Maternal blood should be drawn at delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **All children and adolescents (through age 18 years)** who have not been immunized against hepatitis B should begin the series during any visit. Providers should make special efforts to immunize children who were born in or whose parents were born in areas of the world where hepatitis B virus infection is moderately or highly endemic.

§ The fourth dose of diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. Tetanus and diphtheria toxoids (Td) is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of diphtheria and tetanus toxoids and pertussis vaccine (DTP), DTaP, or diphtheria and tetanus toxoids (DT). Subsequent routine Td boosters are recommended every 10 years.

¶ Three *Haemophilus influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If Hib conjugate vaccine (PRP-OMP) (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months unless approved by the Food and Drug Administration for these ages.

** An all-inactivated poliovirus vaccine (IPV) schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at age 2 months, age 4 months, between ages 6 and 18 months, and between ages 4 and 6 years. Oral poliovirus vaccine should be used only in selected circumstances (*1*).

†† The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2–23 months. It is also recommended for certain children age 24–59 months (*2*).

§§ The second dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who previously have not received the second dose should complete the schedule no later than the routine visit to a health-care provider at age 11–12 years.

¶¶ Varicella vaccine (Var) is recommended at any visit on or after the first birthday for susceptible children, (i.e., those who lack a reliable history of chickenpox [as judged by a health-care provider) and who have not been immunized)]. Susceptible persons aged ≥13 years should receive two doses given at least 4 weeks apart.

*** Hepatitis A vaccine (Hep A) is recommended for use in selected states and/or regions, and for certain high-risk groups. Information is available from local public health authorities (*3*).

Additional information about the immunization schedule is available on the National Immunization Program World-Wide Web site, http://www.cdc.gov/nip, or by telephone, (800)232-2522 (English) or (800)232-0233 (Spanish).

Childhood Immunization Schedule — Continued

Pneumococcal Conjugate Vaccine

In February 2000, the Food and Drug Administration licensed a heptavalent pneumococcal polysaccharide-protein conjugate vaccine (PCV) (Prevnar™,* Wyeth Lederle Vaccines and Pediatrics, Philadelphia, Pennsylvania) for use among infants and young children. All children aged 2–23 months should receive four doses of PCV intramuscularly at ages 2, 4, 6, and 12–15 months. ACIP also recommends the vaccine for children aged 24–59 months who are at increased risk for pneumococcal disease (e.g., children with sickle cell hemoglobinopathies, human immunodeficiency virus infection, and other immunocompromising or chronic medical conditions). For these children, ACIP recommends two doses of PCV administered 2 months apart followed by one dose of a 23-valent pneumococcal polysaccharide vaccine (PPV 23) administered two or more months after the second dose of PCV. ACIP also recommends that PCV be considered for all other children aged 24–59 months, with priority given to children aged 24–35 months, American Indian/Alaska Native and black children, and children who attend child-care centers. ACIP recommends one dose of PCV for children in these groups. Additional information on the use of PCV can be found in the ACIP statement (*2*).

Hepatitis A Vaccination Recommendation

ACIP continues to recommend hepatitis A vaccine (Hep A) for routine use in some states and regions. For 2001, the recommendation has been extended to include adolescents through age 18 years and for persons in certain high-risk groups (i.e., persons traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and noninjectable drugs, persons who have clotting-factor disorders, persons working with nonhuman primates, and persons with chronic liver disease). The hepatitis A vaccine label is shaded on the 2001 Immunization Schedule to indicate its use in selected states and regions, and for certain high-risk groups. Providers can contact their local public health authority for the current recommendations for hepatitis A vaccination in their community. Additional information on the use of Hep A can be found in the ACIP statement (*3*).

Vaccine Information Statements

The National Childhood Vaccine Injury Act requires that all health-care providers give to parents or patients copies of Vaccine Information Statements before administering each dose of the vaccines listed in this schedule. Vaccine Information Statements, developed by CDC, can be obtained from state health departments and CDC's World-Wide Web site, http://www.cdc.gov/nip/publications/VIS. Instructions on use of the Vaccine Information Statements are available at http://www.cdc.gov/nip/publications/VIS/vis-Instructions.pdf.

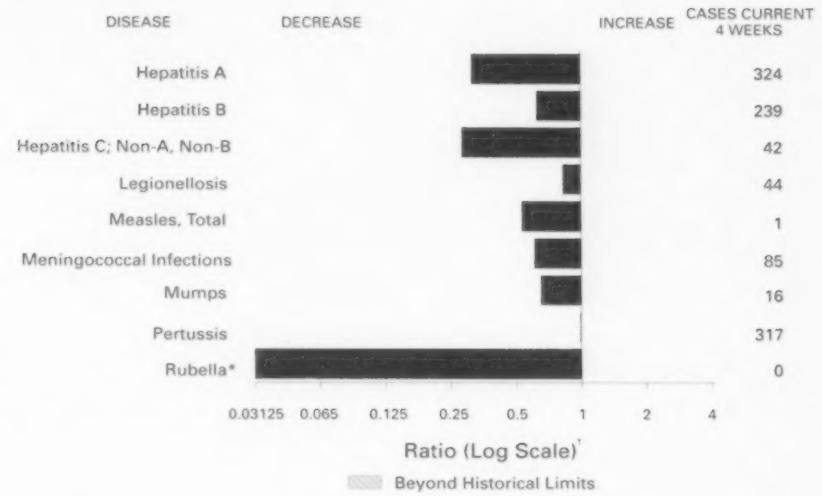
References

1. CDC. Poliomyelitis prevention in the United States: updated recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49(no. RR-5).
2. CDC. Preventing pneumococcal disease among infants and young children: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49(no. RR-9).
3. CDC. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(no. RR-12).

*Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services.

(Continued on page 19)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending January 6, 2001, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 1 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending January 6, 2001 (1st Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	-	Psittacosis*	-
Cholera	-	Q fever*	-
Cyclosporiasis*	-	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	-
Ehrlichiosis: human granulocytic (HGE)*	-	Rubella, congenital syndrome	-
human monocytic (HME)*	-	Streptococcal disease, invasive, group A	18
Encephalitis: California serogroup viral*	-	Streptococcal toxic-shock syndrome*	-
eastern equine*	-	Syphilis, congenital§	-
St. Louis*	-	Tetanus	-
western equine*	-	Toxic-shock syndrome	3
Hansen disease (leprosy)*	-	Trichinosis	-
Hantavirus pulmonary syndrome*†	-	Tularemia*	-
Hemolytic uremic syndrome, postdiarrheal*	-	Typhoid fever	2
HIV infection, pediatric*†	-	Yellow fever	-
Plague	-		

-: No reported cases.
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update November 26, 2000.
§ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	-	-	2,472	9,235	7	6	4	13	-	25
NEW ENGLAND	-	-	198	417	3	-	2	1	-	4
Maine	-	-	-	17	1	-	-	-	-	-
N.H.	-	-	2	19	-	-	-	-	-	2
Vt.	-	-	8	9	2	-	-	-	-	-
Mass.	-	-	188	188	-	-	2	1	-	-
R.I.	-	-	-	46	-	-	-	-	-	-
Conn.	-	-	-	138	-	-	-	-	-	2
MID. ATLANTIC	-	-	15	883	-	-	1	-	-	2
Upstate N.Y.	-	-	N	N	-	-	1	-	-	1
N.Y. City	-	-	-	437	-	-	-	-	-	-
N.J.	-	-	15	167	-	-	-	-	-	-
Pa.	-	-	-	279	-	-	N	N	-	1
E.N. CENTRAL	-	-	539	1,705	-	2	-	4	-	2
Ohio	-	-	94	563	-	-	-	1	-	-
Ind.	-	-	-	131	-	-	-	-	-	1
Ill.	-	-	239	654	-	-	-	2	-	-
Mich.	-	-	206	-	-	1	-	1	-	1
Wis.	-	-	-	357	-	1	-	N	-	-
W.N. CENTRAL	-	-	46	521	-	-	-	3	-	6
Minn.	-	-	-	152	-	-	-	-	-	3
Iowa	-	-	-	7	-	-	-	1	-	-
Mo.	-	-	-	261	-	-	-	2	-	1
N. Dak.	-	-	-	10	-	-	-	-	-	-
S. Dak.	-	-	-	24	-	-	-	-	-	-
Nebr.	-	-	27	24	-	-	-	-	-	1
Kans.	-	-	18	56	-	-	-	-	-	1
S. ATLANTIC	-	-	512	1,314	2	-	-	-	-	1
Del.	-	-	41	52	-	-	-	-	-	-
Md.	-	-	122	125	1	-	-	-	-	-
D.C.	-	-	6	N	1	-	-	-	U	U
Va.	-	-	-	167	-	-	-	-	-	1
W. Va.	-	-	-	30	-	-	-	-	-	-
N.C.	-	-	251	-	-	-	-	-	-	-
S.C.	-	-	-	254	-	-	-	-	-	-
Ga.	-	-	-	342	-	-	-	-	-	-
Fla.	-	-	92	301	-	-	-	-	-	-
E.S. CENTRAL	-	-	220	484	-	1	-	-	-	-
Ky.	-	-	-	98	-	-	-	-	-	-
Tenn.	-	-	92	248	-	-	-	-	-	-
Ala.	-	-	-	137	-	1	-	-	-	-
Miss.	-	-	128	1	-	-	-	-	-	-
W.S. CENTRAL	-	-	465	1,894	-	-	-	1	-	5
Ark.	-	-	-	72	-	-	-	-	-	1
La.	-	-	315	432	-	-	-	-	-	1
Okla.	-	-	150	155	-	-	-	-	-	1
Tex.	-	-	-	1,235	-	-	-	1	-	2
MOUNTAIN	-	-	68	591	-	2	-	-	-	3
Mont.	-	-	-	4	-	-	-	-	-	-
Idaho	-	-	31	25	-	-	-	-	-	-
Wyo.	-	-	3	12	-	-	-	-	-	1
Colo.	-	-	-	108	-	2	-	-	-	1
N. Mex.	-	-	-	71	-	-	-	-	-	-
Ariz.	-	-	34	257	-	-	-	-	-	1
Utah	-	-	-	72	-	N	-	-	-	-
Nev.	-	-	-	42	-	-	-	-	-	-
PACIFIC	-	-	410	1,426	2	1	1	4	-	2
Wash.	-	-	204	190	N	N	-	-	-	1
Oreg.	-	-	-	-	-	-	1	-	-	-
Calif.	-	-	188	1,122	2	1	-	3	-	-
Alaska	-	-	15	24	-	-	-	-	-	-
Hawaii	-	-	3	90	-	-	-	1	-	1
Guam	-	-	-	-	-	-	N	N	U	U
P.R.	-	-	-	U	-	-	-	-	U	U
V.I.	-	-	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update November 26, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001[1]	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	1,272	5,265	2	68	4	8	-	5	23
NEW ENGLAND	65	124	-	1	-	2	-	1	1
Maine	-	-	-	-	-	1	-	-	-
N.H.	-	2	-	-	-	-	-	-	-
Vt.	2	-	-	-	-	-	-	-	-
Mass.	63	57	-	1	-	1	-	1	-
R.I.	-	9	-	-	-	-	-	-	-
Conn.	-	56	-	-	-	-	-	-	1
MID. ATLANTIC	11	360	-	7	-	-	-	-	14
Upstate N.Y.	4	8	-	-	-	-	-	-	-
N.Y. City	-	136	-	-	-	-	-	-	4
N.J.	7	118	-	7	-	-	-	-	8
Pa.	-	98	-	-	-	-	-	-	2
E.N. CENTRAL	245	1,115	1	8	4	2	-	-	-
Ohio	56	369	-	-	4	1	-	-	-
Ind.	-	74	-	-	-	-	-	-	-
Ill.	123	503	-	2	-	-	-	-	-
Mich.	67	-	1	6	-	1	-	-	-
Wis.	-	169	-	-	-	-	-	U	U
W.N. CENTRAL	5	258	1	11	-	-	-	-	-
Minn.	-	70	-	-	-	-	-	-	-
Iowa	-	6	-	-	-	-	-	-	-
Mo.	-	158	1	11	-	-	-	-	-
N. Dak.	-	1	-	-	-	-	-	-	-
S. Dak.	5	3	-	-	-	-	-	-	-
Nebr.	-	17	-	-	-	-	-	-	-
Kans.	-	3	-	-	-	-	-	-	-
S. ATLANTIC	370	1,347	-	-	-	3	-	3	7
Del.	25	27	-	-	-	-	-	-	1
Md.	31	121	-	-	-	2	-	2	6
D.C.	1	58	-	-	-	-	-	1	-
Va.	-	212	-	-	-	-	-	-	-
W. Va.	-	10	-	-	N	N	-	-	-
N.C.	249	-	-	-	-	1	-	-	-
S.C.	-	416	-	-	-	-	-	-	-
Ga.	1	279	-	-	-	-	-	-	-
Fla.	63	224	-	-	-	-	-	-	-
E.S. CENTRAL	192	369	-	12	-	-	-	-	-
Ky.	-	62	-	-	-	-	-	-	-
Tenn.	74	216	-	-	-	-	-	-	-
Ala.	-	91	-	-	-	-	-	-	-
Miss.	118	-	-	12	-	-	-	-	-
W.S. CENTRAL	284	1,152	-	17	-	1	-	-	-
Ark.	-	40	-	-	-	-	-	-	-
La.	206	355	-	6	-	-	-	-	-
Okla.	78	69	-	-	-	-	-	-	-
Tex.	-	688	-	11	-	1	-	-	-
MOUNTAIN	12	210	-	3	-	-	-	-	-
Mont.	-	-	-	-	-	-	-	-	-
Idaho	2	2	-	-	-	-	-	-	-
Wyo.	-	1	-	1	-	-	-	-	-
Colo.	-	101	-	1	-	-	-	-	-
N. Mex.	-	13	-	1	-	-	-	-	-
Ariz.	10	55	-	-	-	-	-	-	-
Utah	-	8	-	-	-	-	-	-	-
Nev.	-	30	-	-	-	-	-	-	-
PACIFIC	88	330	-	9	-	-	-	1	1
Wash.	43	32	-	-	-	-	-	-	-
Oreg.	-	-	-	2	N	N	-	-	-
Calif.	40	283	-	7	-	-	-	1	1
Alaska	3	5	-	-	-	-	-	-	-
Hawaii	2	10	-	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	U	U	-	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	5	16	16	50	94	387	-	455
NEW ENGLAND	-	1	5	5	17	15	-	26
Maine	-	-	-	-	2	3	-	-
N.H.	-	-	-	-	-	-	-	1
Vt.	-	-	3	1	1	-	-	-
Mass.	-	1	2	3	14	11	-	17
R.I.	-	-	-	-	-	-	-	1
Conn.	-	-	-	1	-	1	-	7
MID. ATLANTIC	-	1	6	11	3	44	-	79
Upstate N.Y.	-	-	6	10	3	-	-	17
N.Y. City	-	-	U	U	-	14	-	28
N.J.	-	-	-	1	-	24	-	11
Pa.	-	1	-	-	-	6	-	23
E.N. CENTRAL	1	2	-	-	13	73	-	32
Ohio	1	1	-	-	11	19	-	14
Ind.	-	-	-	-	-	-	-	9
Ill.	-	1	-	-	-	31	-	-
Mich.	-	-	-	-	2	12	-	4
Wis.	-	-	-	-	-	11	-	5
W.N. CENTRAL	-	2	3	5	5	16	-	26
Minn.	-	-	-	2	-	-	-	9
Iowa	-	-	2	-	-	-	-	4
Mo.	-	1	1	-	1	12	-	6
N. Dak.	-	-	-	-	-	-	-	1
S. Dak.	-	-	-	1	3	1	-	3
Nebr.	-	-	-	-	1	1	-	1
Kans.	-	1	-	2	-	2	-	2
S. ATLANTIC	1	3	-	19	14	34	-	83
Del.	-	-	-	-	-	1	-	2
Md.	1	3	-	4	5	15	-	12
D.C.	-	-	-	-	-	-	U	U
Va.	-	-	-	4	-	-	-	9
W. Va.	-	-	-	2	-	-	-	1
N.C.	-	-	-	6	8	17	-	12
S.C.	-	-	-	-	-	-	-	8
Ga.	-	-	-	-	-	-	-	33
Fla.	-	-	-	3	1	1	-	6
E.S. CENTRAL	-	-	-	-	9	30	-	16
Ky.	-	-	-	-	-	6	-	1
Tenn.	-	-	-	-	1	-	-	8
Ala.	-	-	-	-	8	6	-	4
Miss.	-	-	-	-	-	18	-	3
W.S. CENTRAL	-	-	-	3	-	42	-	41
Ark.	-	-	-	-	-	2	-	7
La.	-	-	-	-	-	3	-	10
Okla.	-	-	-	3	-	-	-	3
Tex.	-	-	-	-	-	37	-	21
MOUNTAIN	-	-	1	3	8	32	-	38
Mont.	-	-	-	1	-	-	-	-
Idaho	-	-	-	-	2	1	-	2
Wyo.	-	-	-	1	-	1	-	-
Colo.	-	-	-	-	1	14	-	7
N. Mex.	-	-	-	-	5	2	-	1
Ariz.	-	-	1	1	-	-	-	20
Utah	-	-	-	-	-	10	-	8
Nev.	-	-	-	-	-	4	-	-
PACIFIC	3	7	1	4	25	101	-	114
Wash.	-	-	-	-	-	-	-	9
Oreg.	1	1	-	-	1	5	-	13
Calif.	2	6	-	4	24	83	-	86
Alaska	-	-	1	-	-	1	-	3
Hawaii	-	-	-	-	-	12	-	3
Guam	-	-	-	-	-	-	U	U
P.R.	-	-	1	1	-	1	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

Reporting Area	Shigellosis* NETSS Cum. 2001	Shigellosis* NETSS Cum. 2000	Shigellosis* PHLIS Cum. 2001	Shigellosis* PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	56	193	-	127	70	87	58	94
NEW ENGLAND	-	3	-	5	1	1	-	-
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-
Mass.	-	1	-	4	1	1	-	-
R.I.	-	-	-	-	-	-	-	-
Conn.	-	2	-	1	-	-	-	-
MID. ATLANTIC	5	18	-	21	-	3	-	1
Upstate N.Y.	5	-	-	4	-	-	-	-
N.Y. City	-	7	-	12	-	1	-	1
N.J.	-	10	-	4	-	2	-	-
Pa.	-	1	-	1	-	-	-	-
E.N. CENTRAL	10	65	-	16	2	19	1	2
Ohio	4	6	-	-	-	-	1	-
Ind.	-	2	-	-	-	5	-	-
Ill.	-	35	-	-	2	14	-	2
Mich.	6	20	-	15	-	-	-	-
Wis.	-	2	-	1	-	-	-	-
W.N. CENTRAL	6	6	-	10	-	-	-	-
Minn.	-	-	-	3	-	-	-	-
Iowa	-	2	-	4	-	-	-	-
Mo.	5	4	-	2	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-
Nebr.	1	-	-	1	-	-	-	-
Kans.	-	-	-	-	-	-	-	-
S. ATLANTIC	13	2	-	8	10	32	2	15
Del.	-	-	-	-	-	-	-	-
Md.	2	-	-	-	1	9	-	-
D.C.	1	-	U	U	-	-	2	-
Va.	-	-	-	4	-	9	-	-
W. Va.	-	-	-	-	-	-	-	1
N.C.	10	1	-	-	8	5	-	-
S.C.	-	-	-	-	-	2	-	14
Ga.	-	-	-	2	-	1	-	-
Fla.	-	1	-	2	1	6	-	-
E.S. CENTRAL	6	12	-	10	54	15	-	2
Ky.	-	1	-	-	-	-	-	-
Tenn.	-	-	-	10	11	15	-	-
Ala.	6	1	-	-	-	-	-	2
Miss.	-	10	-	-	43	-	-	-
W.S. CENTRAL	-	44	-	42	1	10	3	26
Ark.	-	-	-	-	-	1	3	-
La.	-	7	-	1	1	3	-	-
Okla.	-	-	-	1	-	2	-	-
Tex.	-	37	-	40	-	4	-	26
MOUNTAIN	6	12	-	7	-	-	-	2
Mont.	-	-	-	-	-	-	-	-
Idaho	-	1	-	1	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
Colo.	-	4	-	1	-	-	-	-
N. Mex.	6	2	-	1	-	-	-	2
Ariz.	-	-	-	4	-	-	-	-
Utah	-	-	-	-	-	-	-	-
Nev.	-	5	-	-	-	-	-	-
PACIFIC	10	31	-	8	2	7	52	46
Wash.	-	-	-	4	2	-	4	-
Oreg.	3	4	-	3	-	-	-	-
Calif.	7	25	-	-	-	7	48	45
Alaska	-	-	-	-	-	-	-	-
Hawaii	-	2	-	1	-	-	-	1
Guam	-	-	U	U	-	-	-	-
P.R.	-	-	U	U	4	3	-	-
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	5	21	21	216	14	94	-	-	-	-	-	1
NEW ENGLAND	1	3	1	4	1	2	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-	-	-
N.H.	-	-	1	-	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	1	-	-	-	-	-	-
Mass.	1	3	-	1	1	-	-	-	-	-	-	-
R.I.	-	-	-	-	-	-	-	-	-	-	-	-
Conn.	-	-	-	3	-	1	U	-	U	-	-	-
MID. ATLANTIC	-	2	-	7	-	14	-	-	-	-	-	-
Upstate N.Y.	-	1	-	-	-	-	-	-	-	-	-	-
N.Y. City	-	1	-	5	-	6	-	-	-	-	-	-
N.J.	-	-	-	1	-	2	-	-	-	-	-	-
Pa.	-	-	-	1	-	6	-	-	-	-	-	-
E.N. CENTRAL	1	4	10	38	7	10	-	-	-	-	-	1
Ohio	-	2	1	10	2	2	-	-	-	-	-	-
Ind.	-	-	-	-	-	-	-	-	-	-	-	-
Ill.	-	2	-	17	-	-	-	-	-	-	-	-
Mich.	1	-	9	9	5	8	-	-	-	-	-	1
Wis.	-	-	-	2	-	-	-	-	-	-	-	-
W.N. CENTRAL	-	-	1	30	1	6	-	-	-	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	-	-	-	-	-	-	-	-	-	-
Mo.	-	-	-	27	-	6	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-	-	-
Nebr.	-	-	1	-	-	-	-	-	-	-	-	-
Kans.	-	-	-	3	-	-	U	-	U	-	-	-
S. ATLANTIC	1	3	3	4	3	15	-	-	-	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-	-
Md.	-	3	2	4	-	4	-	-	-	-	-	-
D.C.	-	-	1	-	-	-	-	-	-	-	-	-
Va.	-	-	-	-	-	-	-	-	-	-	-	-
W. Va.	-	-	-	-	-	-	U	-	U	-	-	-
N.C.	-	-	-	-	3	11	-	-	-	-	-	-
S.C.	-	-	-	-	-	-	-	-	-	-	-	-
Ga.	1	-	-	-	-	-	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	-	-	1	22	-	5	-	-	-	-	-	-
Ky.	-	-	-	-	-	-	U	-	U	-	-	-
Tenn.	-	-	1	-	-	-	-	-	-	-	-	-
Ala.	-	-	-	1	-	-	-	-	-	-	-	-
Miss.	-	-	-	21	-	5	-	-	-	-	-	-
W.S. CENTRAL	-	1	-	47	-	2	-	-	-	-	-	-
Ark.	-	-	-	-	-	-	-	-	-	-	-	-
La.	-	1	-	2	-	2	-	-	-	-	-	-
Okla.	-	-	-	-	-	-	-	-	-	-	-	-
Tex.	-	-	-	45	-	-	U	-	U	-	-	-
MOUNTAIN	1	1	3	5	-	4	-	-	-	-	-	-
Mont.	-	-	-	-	-	-	U	-	U	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	-	2	2	-	3	-	-	-	-	-	-
N. Mex.	1	-	1	-	-	1	-	-	-	-	-	-
Ariz.	-	-	-	-	-	-	-	-	-	-	-	-
Utah	-	1	-	2	-	-	-	-	-	-	-	-
Nev.	-	-	-	1	-	-	-	-	-	-	-	-
PACIFIC	1	7	2	59	2	36	-	-	-	-	-	-
Wash.	-	-	-	-	-	-	-	-	-	-	-	-
Oreg.	1	2	-	5	1	2	-	-	-	-	-	-
Calif.	-	2	2	53	1	34	-	-	-	-	-	-
Alaska	-	1	-	-	-	-	-	-	-	-	-	-
Hawaii	-	2	-	1	-	-	-	-	-	-	-	-
Guam	-	-	-	-	-	-	U	-	U	-	-	-
P.R.	-	-	-	1	-	-	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
† Of 1 case among children aged <5 years, serotype was reported for 0 and 0 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	10	45	-	-	1	8	8	90	-	-	-
NEW ENGLAND	1	1	-	-	-	5	5	28	-	-	-
Maine	-	1	-	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	4	4	7	-	-	-
Mass.	1	-	-	-	-	1	1	21	-	-	-
R.I.	-	-	-	-	-	-	-	-	-	-	-
Conn.	-	-	U	-	-	U	-	-	U	-	-
MID. ATLANTIC	1	4	-	-	-	-	-	4	-	-	-
Upstate N.Y.	1	-	-	-	-	-	-	-	-	-	-
N.Y. City	-	1	-	-	-	-	-	4	-	-	-
N.J.	-	1	-	-	-	-	-	-	-	-	-
Pa.	-	2	-	-	-	-	-	-	-	-	-
E.N. CENTRAL	2	9	-	-	1	1	1	28	-	-	-
Ohio	1	1	-	-	-	-	-	26	-	-	-
Ind.	-	-	-	-	-	-	-	-	-	-	-
Ill.	-	4	-	-	-	-	-	1	-	-	-
Mich.	1	2	-	-	1	1	1	1	-	-	-
Wis.	-	2	-	-	-	-	-	-	-	-	-
W.N. CENTRAL	-	6	-	-	-	1	1	-	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	-	-	-	-	-	-	-	-	-
Mo.	-	6	-	-	-	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	1	1	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-
Kans.	-	-	U	-	-	U	-	-	U	-	-
S. ATLANTIC	3	3	-	-	-	-	-	5	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-
Md.	2	2	-	-	-	-	-	2	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	-	-	-	-	-	-	-	-	-	-	-
W. Va.	-	-	U	-	-	U	-	-	U	-	-
N.C.	-	1	-	-	-	-	-	3	-	-	-
S.C.	-	-	-	-	-	-	-	-	-	-	-
Ga.	1	-	-	-	-	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	-	1	-	-	-	-	-	10	-	-	-
Ky.	-	1	U	-	-	U	-	8	U	-	-
Tenn.	-	-	-	-	-	-	-	-	-	-	-
Ala.	-	-	-	-	-	-	-	2	-	-	-
Miss.	-	-	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	-	6	-	-	-	-	-	-	-	-	-
Ark.	-	-	-	-	-	-	-	-	-	-	-
La.	-	5	-	-	-	-	-	-	-	-	-
Okla.	-	-	-	-	-	-	-	-	-	-	-
Tex.	-	1	U	-	-	U	-	-	U	-	-
MOUNTAIN	1	2	-	-	-	1	1	9	-	-	-
Mont.	-	-	U	-	-	U	-	-	U	-	-
Idaho	1	1	-	-	-	1	1	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	1	-	-	-	-	-	3	-	-	-
N. Mex.	-	-	-	-	N	-	-	4	-	-	-
Ariz.	-	-	-	-	-	-	-	-	-	-	-
Utah	-	-	-	-	-	-	-	2	-	-	-
Nev.	-	-	-	-	-	-	-	-	-	-	-
PACIFIC	2	13	-	-	-	-	-	6	-	-	-
Wash.	-	-	-	-	-	-	-	-	-	-	-
Oreg.	2	2	N	N	N	-	-	3	-	-	-
Calif.	-	11	-	-	-	-	-	2	-	-	-
Alaska	-	-	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	1	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	1	-	-	-	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending January 6, 2001 (1st Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	601	420	103	44	18	16	74
Boston, Mass.	213	133	43	18	9	10	30
Bridgeport, Conn.	36	29	4	2	1	-	2
Cambridge, Mass.	13	12	1	-	-	-	1
Fall River, Mass.	21	17	3	1	-	-	2
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	23	16	2	3	2	-	3
Lynn, Mass.	13	9	2	2	-	-	1
New Bedford, Mass.	45	35	9	1	-	-	6
New Haven, Conn.	50	37	7	3	2	1	6
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	6	5	1	-	-	-	2
Springfield, Mass.	57	35	13	3	4	2	5
Waterbury, Conn.	45	35	5	4	-	1	6
Worcester, Mass.	79	57	13	7	-	2	10
MID. ATLANTIC	2,294	1,635	443	142	34	36	122
Albany, N.Y.	69	53	9	5	-	2	7
Allentown, Pa.	23	21	-	-	1	-	2
Buffalo, N.Y.	124	97	21	4	1	1	8
Camden, N.J.	55	37	10	7	-	1	4
Elizabeth, N.J.	23	18	3	2	-	-	-
Erie, Pa.§	51	39	10	1	-	-	3
Jersey City, N.J.	61	45	10	4	1	1	-
New York City, N.Y.	1,201	835	265	69	18	13	50
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	21	11	8	1	1	-	2
Philadelphia, Pa.	275	176	57	27	7	8	8
Pittsburgh, Pa.§	68	51	4	6	1	6	7
Reading, Pa.	20	16	3	1	-	-	-
Rochester, N.Y.	163	122	22	11	4	4	14
Schenectady, N.Y.	32	23	8	1	-	-	3
Scranton, Pa.§	U	U	U	U	U	U	U
Syracuse, N.Y.	55	46	6	2	-	1	3
Trenton, N.J.	23	18	4	1	-	-	6
Utica, N.Y.	30	27	3	-	-	-	5
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,782	1,245	336	97	41	63	134
Akron, Ohio	63	49	9	4	1	-	4
Canton, Ohio	27	18	7	-	-	2	2
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	66	45	16	1	3	1	12
Cleveland, Ohio	120	80	20	7	5	8	12
Columbus, Ohio	191	132	38	7	4	10	18
Dayton, Ohio	128	101	21	4	1	1	7
Detroit, Mich.	250	146	56	30	6	12	18
Evansville, Ind.	U	U	U	U	U	U	U
Fort Wayne, Ind.	63	46	16	-	1	-	4
Gary, Ind.	20	12	5	3	-	-	-
Grand Rapids, Mich.	71	54	8	3	1	5	9
Indianapolis, Ind.	214	139	44	16	11	4	12
Lansing, Mich.	75	57	11	2	-	5	6
Milwaukee, Wis.	134	97	23	10	3	1	14
Peoria, Ill.	53	38	10	-	2	3	3
Rockford, Ill.	65	51	9	3	1	1	6
South Bend, Ind.	75	56	17	-	-	2	5
Toledo, Ohio	97	70	15	3	2	7	1
Youngstown, Ohio	70	54	11	4	-	1	1
W.N. CENTRAL	753	546	124	48	24	11	45
Des Moines, Iowa	61	50	5	4	-	2	9
Duluth, Minn.	31	23	4	2	-	2	2
Kansas City, Kans.	33	24	3	2	3	1	4
Kansas City, Mo.	73	52	14	5	2	-	4
Lincoln, Nebr.	49	40	6	1	1	1	2
Minneapolis, Minn.	134	103	21	7	1	2	9
Omaha, Nebr.	83	52	14	7	8	2	8
St. Louis, Mo.	83	63	13	5	2	-	-
St. Paul, Minn.	113	79	24	7	2	1	3
Wichita, Kans.	93	60	20	8	5	-	4
S. ATLANTIC	1,186	815	232	87	25	27	76
Atlanta, Ga.	116	67	31	12	2	4	3
Baltimore, Md.	187	131	38	14	1	3	18
Charlotte, N.C.	110	77	18	9	3	3	6
Jacksonville, Fla.	167	125	31	7	1	3	15
Miami, Fla.	76	53	17	3	3	-	6
Norfolk, Va.	52	32	10	4	2	4	1
Richmond, Va.	67	42	14	7	1	3	6
Savannah, Ga.	54	43	9	1	-	1	5
St. Petersburg, Fla.	72	58	5	5	1	3	1
Tampa, Fla.	171	122	27	17	4	1	14
Washington, D.C.	101	55	29	8	7	2	1
Wilmington, Del.	13	10	3	-	-	-	-
E.S. CENTRAL	847	585	174	53	16	19	82
Birmingham, Ala.	165	125	29	10	-	1	20
Chattanooga, Tenn.	66	49	12	3	2	-	6
Knoxville, Tenn.	100	73	19	7	-	1	7
Lexington, Ky.	53	34	15	1	2	1	3
Memphis, Tenn.	170	119	35	10	3	3	18
Mobile, Ala.	99	66	20	8	1	4	6
Montgomery, Ala.	50	27	12	4	3	4	8
Nashville, Tenn.	144	92	32	10	5	5	14
W.S. CENTRAL	1,355	933	262	102	32	26	95
Austin, Tex.	101	66	19	10	2	4	15
Baton Rouge, La.	4	1	3	-	-	-	-
Corpus Christi, Tex.	40	29	8	1	-	2	5
Dallas, Tex.	218	141	41	26	6	4	19
El Paso, Tex.	94	70	17	3	3	1	4
Ft. Worth, Tex.	131	89	29	7	3	3	1
Houston, Tex.	276	188	56	25	5	2	18
Little Rock, Ark.	74	42	19	2	6	5	-
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	221	162	36	16	6	2	18
Shreveport, La.	58	38	16	3	1	-	4
Tulsa, Okla.	138	107	19	9	-	3	11
MOUNTAIN	857	608	174	42	22	11	61
Albuquerque, N.M.	124	89	26	7	1	1	11
Boise, Idaho	39	27	8	3	1	-	5
Colo. Springs, Colo.	52	42	5	1	1	3	4
Denver, Colo.	116	82	23	4	4	3	8
Las Vegas, Nev.	222	154	48	11	6	3	14
Ogden, Utah	29	23	4	1	-	1	-
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	32	21	7	3	1	-	1
Salt Lake City, Utah	120	94	15	7	4	-	11
Tucson, Ariz.	123	76	38	5	4	-	7
PACIFIC	1,166	842	214	75	21	13	123
Berkeley, Calif.	18	10	7	1	-	-	2
Fresno, Calif.	62	44	12	4	2	-	7
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	60	45	13	1	1	-	2
Long Beach, Calif.	35	22	10	1	-	2	6
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	28	22	4	-	-	2	2
Portland, Oreg.	U	U	U	U	U	U	U
Sacramento, Calif.	172	111	47	6	7	1	17
San Diego, Calif.	143	101	18	17	4	2	18
San Francisco, Calif.	140	104	18	11	5	2	22
San Jose, Calif.	172	128	30	11	-	3	20
Santa Cruz, Calif.	30	25	5	-	-	-	5
Seattle, Wash.	128	82	26	17	2	1	7
Spokane, Wash.	66	57	9	-	-	-	6
Tacoma, Wash.	112	91	15	6	-	-	9
TOTAL	10,841¶	7,629	2,062	690	233	224	812

U: Unavailable. -:No reported cases.
*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.

Childhood Immunization Schedule — Continued

4. CDC. Recommended childhood immunization schedule—United States, 2000. MMWR 2000;49:35–8,47.
5. American Academy of Pediatrics. Active and passive immunization. In: Pickering LK, ed. 2000 Red book: report of the Committee on Infectious Diseases. 25th ed. Elk Grove Village, Illinois: American Academy of Pediatrics, 2000:1–81.

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